Southern Inyo Healthcare District
501 E. Locust Street
P.O. Box 1009
Lone Pine, CA 93545
Main Number: (760)876-5501
Fax: (760)876-4388

NOTICE OF AVAILABILITY OF UNCOMPENSATED SERVICES
(EFFECTIVE FOR 2010)

Date: _____, 2010

Dear: _____,

Southern Inyo Hospital is required by law to give a reasonable amount of its services free or at a reduced charge to persons who cannot afford to pay for care and meet the poverty guidelines.

You can apply for "uncompensated services" for the following: Emergency Room services, Occupational Therapy, Physical Therapy, Skilled Nursing, and Outpatient Hospital Services. Patient Financial Assistance applications and information regarding our Charity Care and Hill-Burton programs may be obtained from Admissions personnel. Services cannot be covered by a third-party or governmental program such as Medicare or Medi-Cal.

You cannot apply for "uncompensated services" for: Physician Charges, Medicare co-insurance or deductible, or patient resource amounts allotted for Nursing Home monthly share of cost.

You are eligible to apply for uncompensated services if your family's income is at or below the following levels:

Family Size	Period	Federal Poverty Guidelines (FPG)	If income is at 101% to 150% (shown below) of FPG, eligible for 75% Discount	If income is at 151% to 200% (shown below) of FPG, eligible for 50% Discount	If income is at 201% to 250% (shown below) of FPG, eligible for 25% Discount
1	Annual	$10,830	$16,245	$21,660	$27,075
2	Annual	$14,570	$21,855	$29,140	$36,425
3	Annual	$18,310	$27,465	$36,620	$45,775
4	Annual	$22,050	$33,075	$44,100	$55,125
5	Annual	$25,790	$38,685	$51,580	$64,475
6	Annual	$29,530	$44,295	$59,060	$73,825
7	Annual	$33,270	$49,905	$66,540	$83,175
8	Annual	$37,010	$55,515	$74,020	$92,525

Note: For families with more than 8 persons, add $3740 for each additional family member.

If you think you may be eligible for uncompensated services, please complete and return the attached application for " Determination of Eligibility" and substantiating documentation of income and Medi-Cal or S.M.S.P. Share of Cost denial notice, if applicable, to the Southern Inyo Hospital Billing Office.

A written determination of your eligibility to receive uncompensated service will be made within 14 working days following the completion and submission of the "Determination of Eligibility" form substantiating documentation of income.

SOUTHERN INYO HEALTHCARE DISTRICT
FINANCIAL ASSISTANCE APPLICATION

PATIENT NAME: _____ **SPOUSE:** _____
ADDRESS: _____ **PHONE:** _____
PATIENT/ACCT# _____ / _____ **SSN #** _____ _____
(PATIENT) (SPOUSE)

FAMILY STATUS: List all dependents that you support

Name	Age	Relationship
_____	_____	_____
_____	_____	_____

(add any additional family members on separate page) **Total Family members:** _____

EMPLOYMENT INFORMATION

Employer: _____ Position: _____
Supervisor/Contact Person: _____ Phone #: _____
If Self Employed – Name of Business: _____

Spouse Employer: _____ Position: _____
Supervisor/Contact Person: _____ Phone #: _____
If Self Employed – Name of Business: _____

CURRENT MONTHLY INCOME:

		Patient	Spouse
	Gross Pay (before deductions)	_____	_____
Add:	Income from Operating Business (self employed)	_____	_____
Add:	Other Income: (include child/spousal support , social security interest, unemployment, real estate rental etc)	_____	_____
Subtract:	Spousal / Child Support Payments Paid	_____	_____
Equals:	Current Monthly Income	_____	_____
	Total Current Monthly Income (add patient+spouse Income from above)	_____	

I certify that the above information is true and accurate to the best of my knowledge. Further, I will apply for any assistance (Medi-Cal, Medicare, Insurance etc) which may be available for payment of my medical charge, and I will take any action reasonable necessary to obtain such assistance and will assign or pay the hospital the amount recovered for medical charges. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

By signing this form, I agree to allow Southern Inyo Healthcare District to check employment and credit history for the purpose of determining my eligibility for a financial discount. I understand that I may be required to provide proof of the information I am providing. Upon approval of my application I agree to pay the patient portion after discount, and understand that I will be sent to collections if I do not make payments as agreed.

_____ _____
Signature of Patient or Guarantor Date

_____ _____
Signature of Spouse Date

ELIGIBILITY DETERMINATION **(For Office Use Only)**

Date Application Received: _____ Income Verified? Yes ___ No

Type of Verification:

_____
_____
_____
_____
_____

Medi-Cal Share of Cost? Yes ___ No ___ If yes, Amount: $

___ The applicant is approved for _____ Hill-Burton Uncompensated Services
_____ Charity Care Services

(VALID FROM: ___/___/___ THRU: ___/___/
(a new application will be required after this date)

___ The applicant is conditionally approved as indicated below:
- ___ proof of Medi-Cal Share of Cost (Copy of Medi-Cal Card) within four weeks of this date _____.
- ___ Conditioned on the availability of uncompensated services at the time services are to be received.

___ The applicant's request for free or reduced charge services has been denied for the following reason(s):

_____
_____
_____
_____
_____

Date of Determination: _____ Conditional ___ Final

Approved by: _____

Revised 05/25/10